

ONTARIO BREAST, PROSTATE, AND COLORECTAL CANCER FOLLOW-UP CARE CLINICAL GUIDANCE SUMMARIES

What is follow-up care?

Follow-up care after the completion of cancer treatment is important to help maintain good health, which consists of activities and processes related to the following major areas: prevention of recurrent and new cancers; surveillance for cancer spread, recurrence, or second cancers; management of the consequences of cancer treatment (e.g., side effects, late effects); and, coordination of care. Surveillance includes monitoring for cancer recurrence or second cancers, and assessing the physical and psychosocial consequences of cancer and its treatment on the survivor. Surveillance should be coordinated and conducted in accordance with evidence-based clinical guidelines.

Purpose:

The purpose of this guideline summary document is to serve as an informational tool for health professionals who are engaged in the follow-up care of breast cancer patients who have completed curative-intent treatment and are clinically disease-free. This information is based on a summary of current evidence-based recommendations from provincial and international clinical practice guidelines, existing published literature, and the consensus of provincial cancer experts where evidence is insufficient. These recommendations are not exhaustive nor intended to replace the independent clinical judgement of the treating professional, and should be considered in accordance with available resources and/or individual patient's needs.

Survivors of Childhood, Adolescent, and Young Adult Cancers:

Adults who have a history of pediatric, adolescent, and young adult cancers (i.e., diagnosis and treatment prior to age 30) are at increased risk for additional late effects and should also be followed according to the Long-Term Follow-Up Guidelines published by the Children's Oncology Group

RESOURCES

FOR ALL CANCER TYPES:

- Canadian Cancer Society Peer Support: 1-800-263-6750 • www.cancer.ca
- Cancer Chat Canada: www.cancerchatcanada.ca
- The Hospice of Windsor & Essex County Wellness Programs: 519-251-2590 • www.thehospice.ca
- Windsor Regional Cancer Centre: 519-253-5253
- RENEW Life After Cancer Program: 519-253-5253 • www.wrhc.on.ca/RENEW

PROSTATE CANCER SPECIFIC RESOURCES:

- Lana Berton – Berton Physiotherapy and Chiropractic: 519-966-8200 • www.bertonphysiotherapy.com
 - Internal and external pelvic examinations performed by Registered Physiotherapist specializing in pelvic conditions. Male conditions treated include post prostatectomy incontinence, urinary stress and urge incontinence, pelvic pain (testicular, penile, and perineum), erectile dysfunction, constipation, fecal incontinence, and pudendal neuralgia and entrapment.
- Willow Health Centre: 519-365-0122 • www.willowhealthcentre.com
 - All Physiotherapists are trained and experienced in treating men's pelvic health, including pre and post prostatectomy pelvic floor muscle training.
 - Registered Social Worker, Marlene Maddocks, MSW, offers counselling for sexual health, including erectile dysfunction/sexual dysfunction in both individual and couple formats.
- Bill Landry – Family Physiotherapy Centre of London: 519-439-6111 • www.fpclondon.com
 - Post prostatectomy continence recovery program includes: incontinence therapy, education on latest exercises specifically for men post prostatectomy, and diagnostic ultrasound imaging to review pelvic function, strength and tone while performing exercises.

BREAST CANCER SPECIFIC RESOURCES:

- Willow Breast Cancer Support Canada: 1-888-778-3100 • www.willow.org
- Canadian Breast Cancer Network: www.cbcn.ca

ONTARIO BREAST CANCER FOLLOW-UP CARE CLINICAL GUIDANCE SUMMARY

Produced by Cancer Care Ontario

Intended patient population: Adult breast cancer survivors who require follow-up care after treatment for breast cancer

Recommended Tests	Year 1-3	Year 4+
<p>Medical follow-up care appointment:</p> <p>a) Medical history and physical examination where indicated, with a focus on:</p> <ul style="list-style-type: none"> • Breasts, regional lymph nodes, chest wall, lungs and abdomen • Arms should be examined for lymphedema <p>b) Any new and persistent or worsening signs/symptoms to watch for, especially:</p> <ul style="list-style-type: none"> • Breast lumps • Mastectomy scar changes • Breast axillary and/or supraclavicular masses/lesions • Bone pain • Cough • Abnormal vaginal bleeding (for women taking tamoxifen) • Vague constitutional symptoms such as: <ul style="list-style-type: none"> • Fatigue • Unexplained weight loss • Anorexia <p>Note: For patients that present with symptoms that could suggest recurrence, investigations should be performed and a referral back to the appropriate specialist should be considered.</p> <p>c) Health promotion and disease prevention counselling, including (but not limited to):</p> <ul style="list-style-type: none"> ○ Diet, exercise, smoking status, alcohol, sun safety, mental health, sexual health, and other informational needs ○ Patients may also be assessed for other special issues, including: fertility, genetic testing, cardiotoxicity, bone health, musculoskeletal health, pain, and neuropathy 	Every 6-12 months	Every 12 months
<p>Mammography:</p> <ul style="list-style-type: none"> • All breast cancer survivors without metastatic disease should receive surveillance mammography, unless they have had a bilateral mastectomy • Mammography for surveillance of women who have had breast reconstruction postmastectomy is not recommended, but there may be a possible benefit in women who have had reconstructions using tissue from another place on their body (i.e., autologous reconstruction), and who have a moderate to high chance of breast cancer occurring again 	Every 12 months	Every 12 months

SPECIAL CONSIDERATIONS

Breast magnetic resonance imaging (MRI) for high risk women in Ontario Breast Screening Program (OBSP):

- Breast cancer survivors who are thought to be at high risk should be referred to Cancer Care Ontario's OBSP High Risk Screening Program for assessment of their eligibility to participate in the program. The OBSP screens eligible high risk breast cancer patients with annual breast mammography and MRI (or, if MRI is not medically appropriate, screening breast ultrasound). This kind of testing is based on scientific evidence and ensures that high risk women receive the benefits of organized screening.
- Women ages 30 to 69 who meet any of the following criteria may be considered for referral to participate in the High Risk OBSP:
 - Is known to have a gene mutation (e.g., BRCA1, BRCA2)

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- Is a first-degree relative (parent, brother, sister or child) of someone who has a gene mutation (e.g., BRCA1, BRCA2)
- Has a personal or family history of breast or ovarian cancer
- Has had radiation therapy to the chest to treat another cancer or condition (e.g., Hodgkin's lymphoma) before age 30 and at least 8 years ago

For additional information on the OBSP and requisition details, please visit: cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/breast-cancer-high-risk-women

Bone mineral density (BMD):

- Screening recommended for patients who are post-menopausal, or are pre-menopausal with risk factors of osteoporosis, or are taking aromatase inhibitors
- Baseline dual-energy x-ray absorptiometry (DEXA) scans should be repeated every 2 years for women taking an aromatase inhibitor, premenopausal women taking tamoxifen and/or a gonadotropin-releasing hormone (GnRH) agonist, and women who have chemotherapy-induced, premature menopause

Breast self-exam (BSE):

- Breast self-examination should be taught to patients who express this preference

Tests NOT Recommended for Routine Surveillance:

- Routine blood tests for certain biomarkers (e.g., CEA, CA15-3, CA27-29) are NOT recommended
- Advanced imaging tests (e.g., PET, CT, radionuclide bone scans) are NOT recommended
- Routine laboratory and radiographic investigations should NOT be carried out for the purpose of detecting distant metastases

COMMON LONG-TERM AND LATE EFFECTS

Physical:

- Surgery-related: pain, numbness or stiffness
- Irradiation-related: erythema, swelling, tenderness and skin edema
- Lymphedema
- Menopausal symptoms associated with systemic therapy

For additional information and resources on symptom and side-effect management, please refer to Cancer Care Ontario's Symptom Management Guides available at: cancercareontario.ca/en/symptom-management

Psychosocial:

- Psychological distress (e.g., depression, anxiety, worry, fear of recurrence)
- Cognitive side-effects
- Changes in sexual function/fertility
- Challenges with body and/or self-image, relationships, and other social role difficulties
- Return to work concerns and financial challenges

For additional information and resources on psychosocial oncology care management, please refer to Cancer Care Ontario's Psychosocial Oncology Guides available at: cancercareontario.ca/en/guidelines-advice/modality/psychosocial-oncology-care

ONTARIO COLORECTAL CANCER FOLLOW-UP CARE CLINICAL GUIDANCE SUMMARY

Produced by Cancer Care Ontario

Intended patient population: Adult patients who have completed primary treatment for stage II or III colorectal cancer cancers and who are without evidence of disease. While there is insufficient evidence to support the inclusion of stage I patients, whether these recommendations can be extrapolated to and can benefit stage I patients is left to the discretion of the healthcare provider.

Recommended Tests	Year 1-3	Year 3-5
<p>Medical follow-up care appointment:</p> <p>a) Medical history and physical examination where indicated</p> <p>b) Any new and persistent or worsening signs/symptoms to watch for, especially:</p> <ul style="list-style-type: none"> • Abdominal pain • Rectal bleeding • Changes in bowel habit • Vague constitutional symptoms such as: • Fatigue • Nausea • Unexplained weight loss <p>Additional new and persistent or worsening signs/symptoms to watch for, specific to rectal cancer:</p> <ul style="list-style-type: none"> • Pelvic pain • Sciatica • Difficulty with urination or defecation <p>Note: For patients that present with symptoms that could suggest recurrence, investigations should be performed and a referral back to the appropriate specialist should be considered.</p> <p>c) Health promotion and disease prevention counselling, including (but not limited to):</p> <ul style="list-style-type: none"> ○ Diet, exercise, smoking status, alcohol, sun safety, mental health, sexual health, and other informational needs 	Every 6 months	Every 6 months
<p>Carcinoembryonic antigen (CEA) blood test:</p> <p>Assess for rising levels; however, primary care providers should be aware there still may be a recurrence in patients with normal CEA levels</p>	Every 6 months	Every 6 months
<p>Diagnostic imaging:</p> <ul style="list-style-type: none"> • Abdominal / Pelvic / Chest Computed Tomography (CT) <p>Note: Alternatively, if local resources and/or patient preference preclude the use of CT, an ultrasound (US) can be substituted for the CT of the abdomen and pelvis, and a chest x-ray can be substituted for the chest CT. Every six to 12 months for three years and then yearly for years four and five is considered a reasonable schedule for these tests.</p>	Every 12 months	Not routine

RECOMMENDED TESTS (continued)

Colonoscopy:

- At 1 year following initial surgery OR within 6 months of completing surgery if a complete colonoscopy was not performed pre-operatively
- Frequency of subsequent surveillance colonoscopies should be dictated by the findings of the previous one, but generally should be performed every 5 years, if the findings of the previous one are normal

Note: If a complete colonoscopy was not performed in the course of diagnosis and staging (e.g., due to obstruction) the included guidelines consistently state that one should be done within six months of completing primary therapy

Sigmoidoscopy:

- For rectal cancer patients who are considered at high risk of local recurrence by the treating physician, sigmoidoscopy may be considered at intervals less than 5 years

TESTS NOT RECOMMENDED FOR ROUTINE SURVEILLANCE

- A complete blood count (CBC) and other routine blood work, aside from CEA, are NOT recommended
- A Fecal Occult Blood Test (FOBT) and Fecal Immunochemical Test (FIT) is NOT recommended

COMMON LONG-TERM AND LATE EFFECTS

Physical:

- Surgery-related: frequent and/or urgent bowel movements or loose bowels (often improves over first few years), gas and/or bloating, incisional hernia, increased risk of bowel obstruction
- Medication-related: peripheral neuropathy (associated with treatment using oxaliplatin), chemotherapy-related cognitive side effects (including difficulty with short-term memory and the ability to concentrate)
- Radiation-related: localized skin changes (i.e., colour, texture, and loss of hair), rectal ulceration and/or bleeding (radiation colitis), anal dysfunction (incontinence), bowel obstruction (from unintended small bowel scarring), infertility, sexuality dysfunction (e.g., vaginal dryness, erectile dysfunction, retrograde ejaculation), second primary cancers in the radiation field (typically about seven years after radiotherapy), bone fracture (e.g., sacral region)
- Other: for patients who received ostomy, stoma care and life-style adjustments will be required

For additional information and resources on symptom and side-effect management, please refer to Cancer Care Ontario's Symptom Management Guides available at: cancercareontario.ca/en/symptom-management

For additional information and resources on ostomy care and management, please refer to applicable sources such as Ostomy Canada Society available at: ostomycanada.ca/information/ostomy-care-2/

Psychosocial:

- Psychological distress (e.g., depression, anxiety, worry, fear of recurrence)
- Cognitive side-effects
- Changes in sexual function/fertility
- Challenges with body and/or self-image, relationships, and other social role difficulties
- Return to work concerns and financial challenges

For additional information and resources on psychosocial oncology care management, please refer to Cancer Care Ontario's Psychosocial Oncology Guides available at: cancercareontario.ca/en/guidelines-advice/modality/psychosocial-oncology-care

ONTARIO PROSTATE CANCER FOLLOW-UP CARE CLINICAL GUIDANCE SUMMARY

Produced by Cancer Care Ontario

Intended patient population: Adult prostate cancer patients who have undergone curative-intent treatment.

Recommended Tests	Year 1	Year 2	Year 3
<p>Medical follow-up care appointment:</p> <p>a) Medical history and physical examination where indicated</p> <p>b) Any new and persistent or worsening signs/symptoms to watch for, especially:</p> <ul style="list-style-type: none"> • Severe and progressive axioskeletal bone pain • Hematuria • New urinary symptoms • Significant incontinence requiring changing of undergarments, pads, or diapers • Urgency • Obstructive symptoms • Voiding discomfort • Nocturia • New bowel symptoms • Rectal bleeding • Rectal pain • Urgency • Change in bowel movement • Vague constitutional symptoms such as: • Fatigue • Unexplained weight loss <p>Note: For patients that present with symptoms that could suggest recurrence, a prostate-specific antigen (PSA) test should be performed and a referral back to the appropriate specialist should be considered.</p> <p>c) Health promotion and disease prevention counselling, including (but not limited to):</p> <ul style="list-style-type: none"> ○ Diet, exercise, smoking status, alcohol, sun safety, mental health, sexual health, and other informational needs 	Every 3 months	Every 6 months	Every 12 months
<p>Prostate-specific antigen (PSA) test:</p> <p>a) For patients following curative-intent treatment with surgery</p>	Every 3 months	Every 6 months	Every 12 months
<p>b) For patients following curative-intent treatment with non-surgery primary therapy (e.g., radiation therapy, cryotherapy, or highintensity focused ultrasound)*</p>	Every 6 months	Every 6 months	Every 12 months (until the end of year 5, then annually thereafter)
<p>*CAUTION: PSA lab test results: PSA lab reports typically flag a PSA value of >4 ng/ml as abnormal, which is considered abnormal and very late in the detection of a recurrence among prostate cancer survivors. Therefore, primary care providers should review the actual values and ensure patients are referred back to the oncologist if any measurable PSA is detected.</p>			

RECOMMENDED TESTS (continued)

For patients on androgen deprivation therapy (ADT):

- Consider annual complete blood count (CBC) to monitor hemoglobin levels, particularly in men presenting with symptoms suggestive of anemia
- Assess risk of fracture for men treated with ADT through baseline DEXA (dual energy x-ray absorptiometry) scan and calculation of a FRAX (WHO fracture risk assessment) score

SPECIAL CONSIDERATIONS

Digital rectal exam (DRE):

- There is insufficient evidence supporting the DRE, specifically as it relates to the detection of recurrence among prostate cancer survivors. Therefore, primary care providers should discuss and collaborate with prostate cancer specialists to identify those patients who may benefit from routine DREs to optimize the ratio of benefit to physical and psychological harm related to routine DREs in prostate cancer survivors.

COMMON LONG-TERM AND LATE EFFECTS

Physical:

- | | | |
|---|--|---|
| • Sexual dysfunction (for all treatments) | • Urinary dysfunction (for those treated with surgery or RT) | • Urgency and frequency symptoms |
| • Erectile dysfunction | • Obstructive symptoms | • Other (mostly for those treated with ADT) |
| • Loss of libido | • Urgency symptoms | • Anemia |
| • Anorgasmia | • Hematuria | • Body composition alterations |
| • Dry ejaculate | • Incontinence requiring urinary pads | • Fatigue (for all treatments) |
| • Climacturia | • Bowel dysfunction (for those treated with RT) | • Gynecomastia/mastodynia |
| • Penile shortening or curvature | • Rectal bleeding | • Hot flushes |
| • Infertility | | • Bone health |

For additional information and resources on symptom and side-effect management, please refer to Cancer Care Ontario's Symptom Management Guides available at: cancercareontario.ca/en/symptom-management

Psychosocial:

- Psychological distress (e.g., depression, anxiety, worry, fear of recurrence)
- Cognitive side-effects
- Changes in sexual function/fertility
- Challenges with body and/or self-image, relationships, and other social role difficulties
- Return to work concerns and financial challenges

For additional information and resources on psychosocial oncology care management, please refer to Cancer Care Ontario's Psychosocial Oncology Guides available at: cancercareontario.ca/en/guidelines-advice/modality/psychosocial-oncology-care

HODGKIN LYMPHOMA

Produced by National Comprehensive Cancer Network

FOLLOW-UP AFTER COMPLETION OF TREATMENT AND MONITORING FOR LATE EFFECTS

- CR should be documented including reversion of PET to "negative" within 3 months following completion of therapy.
- It is recommended that the patient be provided with a treatment summary at the completion of his/her therapy, including details of radiation therapy, organs at risk, and cumulative anthracycline dosage given.
- Follow-up with an oncologist is recommended, especially during the first 5 years after treatment to detect recurrence, and then annually due to the risk of late complications including second cancers and cardiovascular disease. Late relapse or transformation to large cell lymphoma may occur in NLPHL.
- The frequency and types of tests may vary depending on clinical circumstances: age and stage at diagnosis, social habits, treatment modality, etc. There are few data to support specific recommendations; these represent the range of practice at NCCN Member Institutions.

FOLLOW-UP AFTER COMPLETION OF TREATMENT UP TO 5 YEARS

- **Interim H&P:** Every 3–6 mo for 1–2 y, then every 6–12 mo until year 3, then annually
- **Annual influenza vaccine**
- **Laboratory studies:**
 - CBC, platelets, ESR (if elevated at time of initial diagnosis), chemistry profile as clinically indicated
 - Thyroid-stimulating hormone (TSH) at least annually if RT to neck.
- Acceptable to obtain a neck/chest/abdomen/pelvis CT scan with contrast, at 6, 12, and 24 mo following completion of therapy, or as clinically indicated. PET/CT only if last PET was Deauville 4-5, to confirm complete response.
- **Counseling:** Reproduction, health habits, psychosocial, cardiovascular, breast self-exam, skin cancer risk, end-of-treatment discussion.
- Surveillance PET should not be done routinely due to risk for false positives. Management decisions should not be based on PET scan alone; clinical or pathologic correlation is needed.

FOLLOW-UP AND MONITORING AFTER 5 YEARS

- **Interim H&P:** Annually
 - Annual blood pressure, aggressive management of cardiovascular risk factors
 - Pneumococcal, meningococcal, and H-flu revaccination after 5–7 y, if patient treated with splenic RT or previous splenectomy (according to CDC recommendations)
 - Annual influenza vaccine
- **Cardiovascular symptoms may emerge at a young age.**
 - Consider stress test/echocardiogram at 10-y intervals after treatment is completed.
 - Consider carotid ultrasound at 10-y intervals if neck irradiation.
- **Laboratory studies:**
 - CBC, platelets, chemistry profile annually
 - TSH at least annually if RT to neck
 - Biannual lipids
 - Annual fasting glucose
- **Annual breast screening:** Initiate 8–10 y post-therapy, or at age 40, whichever comes first, if chest or axillary radiation. The NCCN Hodgkin Lymphoma Guidelines Panel recommends breast MRI in addition to mammography for women who received irradiation to the chest between ages 10–30 y, which is consistent with the American Cancer Society (ACS) Guidelines. Consider referral to a breast specialist.
- Perform other routine surveillance tests for cervical, colorectal, endometrial, lung, and prostate cancer as per the ACS Cancer Screening Guidelines.
- **Counseling:** Reproduction, health habits, psychosocial, cardiovascular, breast self-exam, and skin cancer risk.
- Treatment summary and consideration of transfer to PCP. Consider a referral to a survivorship clinic.